UNIVERSITY OF FLORIDA FINANCIAL ASSISTANCE PROGRAM

If you do not have health insurance, you *may* be eligible for the UF Financial Assistance Program (FAP). Depending on your household income, you may qualify for a full FAP discount (meaning you can receive some services at UF Health for free!).

There are four ways to submit your application:

01 For fastest processing, drop application and supporting documents off at Patient Financial Services Customer Service (3300 SW Williston Road, Gainesville, FL, 32608). You should go Monday-Friday 9a-4p.

02 You can email ptreldept@shands.ufl.edu.

03 You can fax it to 352-627-4648.

04 You can mail it to UF Health Customer Service, PO Box 100334, Gainesville, FL, 32610-0334. This can take 6-8 weeks for processing and is the slowest way to submit.

To expedite the process:

If you have income, bring requested documentation of that income (see attached list of documents).

If you have no income, bring the attached letter of support or unemployment.

If your medical provider ordered labs for you to complete at UF Health,

You may have these done on a walk-in basis at Shands Medical Plaza (address: 1549 Gale Lemerand Drive, Ground Floor, Gainesville, FL 32610). They are open from 6:00am-5:30pm and you do not need an appointment for these labs. You will receive a bill for these labs in the mail. When you receive the bill, you should complete and submit the FAP application. Do not submit the application until you have incurred a bill!

If your medical provider has referred you to a specialty doctor

(For example, cardiology, gynecology, etc.), you should receive a call from the specialty office asking you to schedule an appointment.

For questions or concerns about this process, you can reach out to:
UF Social Work team at (352) 265-9802, UF Customer Service at (352) 265-7906, or email ptreldept@shands.ufl.edu

RE: Account Number: MRN:

Dear:

We are providing an application because you may qualify for our Financial Assistance Program. **In order to be considered for full assistance, you must complete, sign and provide all supporting documentation required from the attached Financial Assistance Application.**

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested. If you fail to provide all the necessary information, your application for Financial Assistance may be denied.

Please read the form carefully as it provides critical information for your approval in our Financial Assistance Program. Any missing or incomplete information will cause your application to be denied, or your approval to be delayed! Please be advised that both signatures, patient/guarantor and witness, are required for your application to be considered for approval.

As you may be aware, the Affordable Care Act went into effect on October 1, 2013. The Act provides all Americans the opportunity to have access to quality, affordable coverage. The Affordable Care Act intends to provide Americans with options and alternatives for health care coverage. Health Insurance Exchanges will provide a marketplace to assist people in choosing options for coverage that may be subsidized through tax credits for many Americans.

If you are interested in what is available, go to Healthcare.gov website that will allow you to enroll as well as provide some helpful FAQ's on the Affordable Healthcare Act.

This program applies to services rendered by the UF Health Gainesville.

Please allow 7 business days for our review process. We will notify you of our determination of qualification by letter. If you have any questions pertaining to this application, please contact one of our representatives at the numbers listed below.

Sincerely,
UF Health - Customer Service Department

**********Financial Assistance Application**********

UF Health
Customer Service
P O Box 100334
Gainesville, Fl 32610-0334

Patient Name:
MRN:
Patient DOB:
Guarantor: Address:
Account Number:

**********DEPENDENTS IN FAMILY**********

(This includes spouse, children under 18 and all others claimed on your and/your spouse's tax return)

Name:(first,middle,last)	DOB:	Name:(first,middle,last)	DOB:
1.		4.	
_____	_____	_____	_____
2.		5.	
_____	_____	_____	_____
3.		6.	
_____	_____	_____	_____

**********PATIENT/GUARANTOR INFORMATION**********

Social Security#:_____ Employer Name:_____
Hourly Pay Rate: $_____ Average Hours Work Per Week:_____
Current Gross Weekly, Monthly or Yearly Income:$_____
If Unemployed, last date worked: ____/___/___

**********SPOUSE INFORMATION**********

Social Security#:_____ Employer Name:_____
Hourly Pay Rate: $_____ Average Hours Work Per Week:_____
Current Gross Weekly, Monthly or Yearly Income:$_____
If Unemployed, last date worked: ____/___/___

**********OTHER INCOME**********

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse	Dependent(s)
Social Security	$_____	$_____	$_____
Pension	$_____	$_____	$_____
Unemployment	$_____	$_____	$_____
Worker's Compensation	$_____	$_____	$_____
VA Benefits	$_____	$_____	$_____
Child Support	$_____	$_____	$_____
Alimony	$_____	$_____	$_____
Rental Income	$_____	$_____	$_____

**********ASSET INFORMATION**********

Please provide supporting documentation for any of the below mentioned items if applicable.

	Patient/Guarantor	Spouse
Home Value	$_____	$_____
Balanced Owed	$_____	$_____
Other Real Property Value/Assets	$_____	$_____
Stocks/Bonds/CDs/IRAs	$_____	$_____
Bank Account: Checking	$_____	$_____
Bank Account: Saving	$_____	$_____

Have you applied for Medicaid or other assistance? Yes/No
If yes and approved please provide your Medicaid number _____.
If yes and you have been denied please provide a copy of the denial letter.
If yes and pending application process please provide application#_____.
If no, please contact your local Medicaid office to determine eligibility.

I certify that the above information is true and accurate. Futhermore, I authorize UF Health to make any inquiries or obtain any information necessary to verify the accuracy of the information contained herein including my employer, the Credit Bureau,my creditors or other financial institution if deemed necessary. In accordance with public law s.817.50 F.S.,providing false information to defraud a hospital for the purpose of obtaining goods or service is a misdemeanor in the second (2nd) degree.

Signature:_____ Date:_____

Witness:_____

Both signatures are required or your application will be denied.

SUPPORTING DOCUMENTATION CHECKLIST

When applying for financial assistant, please provide complete documentation. If there is a failure to provide adequate documentation assistance may not be extended

☐ **EMPLOYMENT**—Please provide verification of all household incomes for the last three (3) months (if employed with the same employer since January 1st of the current year the most recent check stub with YTD Gross Income will suffice) A signed letter of wage verification from your employer(s) is also acceptable

☐ **LETTER OF UNEMPLOYEMENT**—If any adult member of the household is unemployed, please provide a letter from **someone outside of the home** stating the length of unemployment.

☐ **LETTER OF SUPPORT**— Please provide a letter from anyone assisting you in meeting your financial needs. This letter must show how assistance is given, in what amounts, and how often. Example: I have given John Doe food and shelter from 01/01/2018 through 03/01/2018.

☐ **SELF EMPLOYED** -- Provide a balance sheet and your profit & loss statement for the last 3 months **(do not include personal expenses), and 3-months bank statements (all business and personal accounts)**

☐ **BANKING ACCOUNTS**—Provide complete copies of bank statements for one month for all accounts (**checking, savings, investments, and/or other bank accounts not listed**)

☐ **SOCIAL SECURITY/SSI**--Provide a copy of your letter from Social Security stating amount received monthly **(Must be current year's benefit letter)**

☐ **VA**--Provide a copy of your award letter from the Veterans Administration. (**Must be current year's benefit letter**)

☐ **PENSION/RETIREMENT/DIVIDENDS/INTEREST**--Provide a copy of your award letter stating the amount you will receive or copies of your check. (**Must be current income**)

☐ **WORKER'S COMPENSATION**--Provide either the award letter detailing your Worker's Compensation benefit allocation and distribution and/or a letter from your assigned adjuster at the Worker's Compensation office.

☐ **UNEMPLOYMENT COMPENSATION**--Provide a copy of your award letter.

☐ **CHILD SUPPORT/ALIMONY** -- Provide a copy of your Divorce Decree/Custody Agreement which states the amount paid and how often or proof of distribution through the Department of Revenue State Disbursement Unit.

☐ **COLLEGE LOANS, GRANTS AND/OR SCHOLARSHIPS**--Provide a copy of loan, grant and/or scholarship award notifications.

☐ **UNUSUAL INCOMES--MORTGAGES, RENTAL PROPERTIES, INSURANCE BENEFITS, ETC.** -- Provide copies of the actual documents showing the amounts received.

***** Please note: If you are applying for Assistance for balances with UF Health in relation to an Automobile Accident *****

You will need to provide your automobile insurance information to UF Health Customer Service. We cannot process your request for financial assistance until all available insurance either pays or denies your bill. Even though collection of your unpaid hospital accounts may be suspended, UF Health Hospital remains entitled to payment of your hospital bills from settlements with those who caused your injuries. If an accident attorney represents you, you also must inform UF Health Customer Service Department of your attorney's name, address and telephone number

If you have any questions regarding your application for financial assistance, please call 352-265-7906 or 888-766-8154.

UF Health Financial Assistance Program

PO BOX 100334 Gainesville, Fl. 32610
(352) 265-7906 fax (352) 627-4648

MRN:
GUAR ID:

In order to consider your application, we need this form filled out by the person who is providing you room and board or knows of your unemployment. This form **CANNOT** be completed by your marital spouse. It can be filled out by your friend, neighbor, roommate, boy/girl- friend, parents, etc., that is aware of your situation. (Please fill out the section(s) that applies to the patient's circumstances).

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Letter of Support

I, _____ know _____ personally and

(Name of person providing support) (Name of Patient)

have provided room and board / support for the named individual since_____to _____.
(Start date) (End date)

The person signed below has stated that due to the patient's circumstances he/she is providing those necessities free of charge or as a loan at this time.

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Letter of Unemployment

I, _____, have personal knowledge that_____

(Name of person who knows you're unemployed) (Name of Patient)

was unemployed from _____ until _____.

(Start Date) (End Date)

Due to this status, he/she is unable to provide the daily necessities such as room and board for themselves.

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_____

Print name of person providing support or knows of unemployment

By signing this form, this does not make you responsible for the bill.

_____

Signature of person providing support or knows of unemployment

_____ ____/____/____

Witness Date

In accordance with public law s.817.50 F.S., providing false information to defraud a hospital for the purposes of obtaining goods or service is a misdemeanor in the second (2nd) degree.